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# BULLETIN NO. 09-17

**TO:** **ALL HOSPITAL, MEDICAL AND HEALTH SERVICE CORPORATIONS, HEALTH INSURANCE COMPANIES AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO TRANSACT BUSINESS IN NEW JERSEY**

**FROM:** **STEVEN M. GOLDMAN, COMMISSIONER**

**RE:** **P. L. 2008, c. 126 – HEALTH BENEFITS COVERAGE FOR HEARING AIDS FOR CHILDREN**

P. L. 2008, c. 126, approved December 30, 2008 and effective March 30, 2009, requires health insurance carriers, including hospital, medical and health service corporations; individual and group health insurance companies; health maintenance organizations (HMOs); health benefits plans issued pursuant to the Individual Health Coverage (IHC) and Small Employer Health Benefits (SEH) Programs; the State Health Benefits Plan (SHBP) and the NJ FamilyCare Program to provide benefits for medically necessary expenses incurred in the purchase of a hearing aid for a covered person 15 years of age or younger. The law further states that benefits may be limited to $1,000 per hearing aid for each hearing-impaired ear every 24 months. Finally, the law specifies in the provisions applicable to commercial plans that the benefits are to be provided to the same extent as for any other conditions covered under the plan.

The Department has received a number of questions concerning implementation of the law. The purpose of this Bulletin is to respond to the various questions received to date and to provide guidance on the Department's interpretation of how the law applies to commercial plans, i.e. plans other than the SHBP and NJ FamilyCare.

Q1 Does the law require coverage of the hearing aids only and not the related services?
A1 No, the law states that coverage shall be provided for the purchase of a hearing aid for each ear when medically necessary and for medically necessary expenses incurred in the purchase of a hearing aid. The Department construes the reference to such expenses to include fittings, examinations and hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants.

Q2 Who determines whether the expenses incurred in the purchase of a hearing aid are medically necessary?
A2 The carrier retains the authority to make the initial determination of whether services associated with the purchase of hearing aid are medically necessary. Such determination is subject to review and reversal by the Independent HealthCare Appeals Program in the

Department of Banking and Insurance pursuant to N.J.S.A. 26:2S-12.

Q3 Does the $1,000 benefit cap apply to just the hearing aid or to the hearing aid and all medically necessary services incurred in the purchase of the hearing aid?
A3 The Department interprets the $1,000 benefit cap as applicable only to the hearing aid. Medically necessary services incurred in connection with the hearing aid, including fittings, examinations, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants, do not accumulate to the $1,000 cap and should be covered as other medical services under the plan and may not be subject to a separate internal benefit limit.

Q4 Does the $1,000 cap apply to the allowed charge or to the benefit paid or credited to the deductible under the plan?
A4 The Department construes the $1,000 cap as applicable to the benefits paid or credited to the deductible, i.e. the paid amount, and not to the allowed charge. For example, if deductible has been satisfied, in network coinsurance is 80% and the negotiated rate for the hearing aid is $1,500, the carrier would apply the coinsurance to the negotiated rate, i.e. compute 80% of $1,500, for a benefit of $1,200. The $1,000 cap would reduce the benefit from $1,200 to $1,000. The $1,000 cap does **not** reduce the $1,500 negotiated rate or allowed charge to $1,000 and permit the carrier to pay 80% of $1,000 or only $800.

Q5 What would happen where a carrier with network-based plans, i.e. plans with only in network benefits or plans with in-network and out of network benefits, does not have audiologists, hearing aid dispensers and other hearing specialists in its network of providers?
A5 The carrier must provide the in-network level of benefits for hearing aids and related medically necessary expenses if it does not have a network of audiologists, hearing aid dispensers and hearing professionals. See N.J.A.C. 11:24-5.1(a) and 9.1(d) and 11:24A-4.10(a).

Q6 Can a carrier treat the hearing aid as durable medical equipment for purposes of determining the appropriate cost sharing?
A6 No. Instead, the cost sharing applicable to primary care provider visits should apply to hearing aids and related medically necessary expenses because the law specifically states that the benefits shall be provided to the same extent as for other conditions.

Q7 When is a covered person considered to no longer be 15 years of age or younger and therefore not subject to the mandate?
A7 A person is considered to be 15 years of age until he or she reaches his 16th birthday and is therefore covered by the mandate until age 16.

Q8 Are hearing aid batteries covered by the mandate?
A8 Since hearing aid batteries are sold over the counter and health benefits plans typically exclude items sold over the counter, the Department does not construe the law as providing that batteries are included in the mandate.

Q9 When does the mandate apply for existing and newly issued plans?
A9 For existing plans, the benefits required by P. L. 2008, c. 126 will take effect on the renewal date of the plan on or following March 30, 2009 (e.g. if an eligible insurance plan renews on January 1, the new benefits would start January 1, 2010. For new plans issued on or after March 30, 2009, the coverage goes into effect at the time the new plan is issued.)

Q10 What plans are subject to P.L. 2008, c. 126?
A10 The law applies to insured plans only; self funded plans (other than the SHBP) and insured plans issued outside of New Jersey are not subject to the law.

Q11 What should carriers include in their policy forms regarding hearing aids for children age 15 and under?
A11 Carriers should list the coverage for hearing aids and medically necessary expenses incurred in the purchase of hearing aids in the covered services and supplies section of the certificate and/or group contract. Carriers should also amend any exclusions that exclude coverage for hearing aids.

Q12 Can carriers make the purchase of a hearing aid subject to pre-certification?
A12 No, because the law requires that hearing aids be covered to the same extent as other medical conditions under the plan.

The Department intends to propose rules to implement the provisions of P.L. 2008, c. 126 consistent with the foregoing responses. Interested parties should monitor the Department's website at www.dobi.state.nj.us where the proposal will be published upon its publication in the New Jersey Register.

Questions on this bulletin may be submitted to Gale Simon, Assistant Commissioner, Life and Health at 609-292-5427 Ext. 50333, gale.simon@dobi.state.nj.us or Ellen DeRosa, Executive Director, Individual Health Coverage Program at 609-633-1882 Ext. 50302, ellen.derosa@dobi.state.nj.us.

5/15/09
Date

/s/ Steven M. Goldman
Steven M. Goldman
Commissioner

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